NAME_____ DATE_____

HAIR LOSS QUESTIONNAIRE

Please tell me more about your hair loss condition by answering the following questions. For some questions you will need to mark the YES or NO box at the right. For other questions, simply write your answers in the spaces provided.

1. When did you *FIRST* notice that you were losing your hair? _____

   What did you notice at that time? ☐ hair "coming out" or shedding ☐ hair looked thinner on scalp ☐ (other)_____

2. Have you recently noticed that your hair loss was worsening? **YES** ☐ **NO** ☐
   If yes, when did you begin to notice it was worsening? _____
   What makes you think it is worsening? _____

3. Please mark the box that best describes your family members' scalp hair
   (*If you have more than one brother or sister, mark the box that describes the brother or sister who has the* <u>least</u> *amount of hair*):

	has a lot of hair	has some thinning	has a small bald area	has a large bald area	has (or had) many bald spots
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐

4. Have you been pregnant at any time before or during the hair loss? **YES** ☐ **NO** ☐
   If yes, when did the pregnancy end? _____

5. Have you had a serious illness at any time before or during the hair loss? **YES** ☐ **NO** ☐
   If yes, please describe the illness and state when it occurred

_____
_____

6. Have you been hospitalized at any time before or during the hair loss? **YES** ☐ **NO** ☐
   If yes, why were you hospitalized and when did you leave the hospital? _____
   _____

7. Have you been under a severe amount of stress at any time before or during the hair loss?

YES ☐ **NO** ☐

If yes, when did it start and end? _____

8. Have you started any special diets at any time before or during the hair loss? **YES** ☐ **NO** ☐

9. Are you a vegetarian? **YES** ☐ **NO** ☐

10. Please list the names of all the medications you are currently taking in the space below.
Check the ones that you were taking when your hair began to fall out.

☐ _____

☐ _____

☐ _____

☐ _____

☐ _____

11. Please list any additional medications that you were taking when your hair began to fall out that you are no longer taking:

_____

_____

_____

_____

12. Please list any vitamins or natural products that you are taking:

_____

_____

_____

_____

13. Are you menopausal? **YES** ☐ **NO** ☐

If you are menopausal, when did menopause occur? _____

If you are menopausal, were your periods (menses) regular prior to menopause? **YES** ☐ **NO** ☐

14. If you are not menopausal, do you get your menstrual period every month? **YES** ☐ **NO** ☐

If yes how often does your period come? every _____ days

15. Have you ever needed to take birth control pills to make your periods regular? **YES** ☐ **NO** ☐

16. Do you have unwanted or excessive hair growth on your body? **YES** ☐ **NO** ☐
Where is the unwanted/excessive hair growth located? _____
_____

17. Do you have hair loss anywhere else on your body? **YES** ☐ **NO** ☐
Where (other than the scalp) is the hair loss located? _____

18. Do you have any abnormal fingernails or toenails? **YES** ☐ **NO** ☐
*If yes, please describe the problem*_____

19. How often do you wash/shampoo your hair? every _____ days

20. How often is your hair chemically processed or straightened (relaxers, Japanese straightening, other)?

☐ Never ☐ Once a week ☐ Once every 2 – 3 weeks ☐ Once every 1 – 2 months

☐ A few times a year

21. How often is your hair heat processed or straightened (e.g. blowdrying/ flat ironing, curling iron)?

☐ Never ☐ Once a week ☐ Once every 2 – 3 weeks ☐ Once every 1 – 2 months

☐ A few times a year

22. How often is your hair dyed, highlighted or otherwise color treated?

☐ Never ☐ Once a week ☐ Once every 2 – 3 weeks ☐ Once every 1 – 2 months

☐ A few times a year

23. Please check all hair styling practices that you have done in the past

☐ braiding ☐ weaves ☐ tight hairstyles (e.g. ponytails)

☐ (other) _____

24. Have you had a biopsy of your scalp to evaluate your hair loss problem? **YES** ☐ **NO** ☐

25. Have you had blood tests done to evaluate your hair loss problem? **YES** ☐ **NO** ☐

*What tests were done?*_____

26. Have your hormones ever been checked to evaluate your hair loss problem? **YES** ☐ **NO** ☐

If yes, when? _____

What was the result? _____

27. Have you ever been told by a doctor that you have a thyroid condition? **YES** ☐ **NO** ☐

28. Have you ever been treated with thyroid hormone? **YES** ☐ **NO** ☐
*When?*_____

29. Have you ever been told by a doctor that you have a low iron level? **YES** ☐ **NO** ☐
*When?*_____

30. Do you (or a family member) have any autoimmune diseases? **YES** ☐ **NO** ☐

Check all that apply:

Lupus	□ *self*	□ *family member (_____)*
Rheumatoid arthritis	□ *self*	□ *family member (_____)*
Celiac disease	□ *self*	□ *family member (_____)*
Type 1 diabetes	□ *self*	□ *family member (_____)*
Sjogrens disease	□ *self*	□ *family member (_____)*
Vitiligo	□ *self*	□ *family member (_____)*
Other (_____)	□ *self*	□ *family member (_____)*

31. Do you have symptoms on the scalp (e.g. itching, pain, burning)? **YES** ☐ **NO** ☐

If yes, indicate which symptom(s) has occurred (please check all that apply):

☐itching ☐tenderness ☐pain ☐burning ☐(other) _____

Where on the scalp do the symptoms occur? ☐ the top ☐the sides ☐the back ☐temples

☐ (other) _____

32. Please list all the prescription and non-prescription treatments that you have tried for your hair loss condition:

Treatment	When was it tried?	For how long?	Did it help?

33. What do you think is the cause of your hair loss?

34. Is there any other important information you would like to share regarding your hair loss?